General Practitioner, Dr B
Final opinion – 01HDC14511

Complaint

On 10 December 2001, I received a complaint from Mrs A concerning services provided to her late daughter, Miss A, by various health providers. On 24 June 2002, I commenced an investigation into the particular services general practitioner Dr B provided to Miss A.

The complaint against Dr B was summarised as follows:

Dr B, a general practitioner, did not provide Miss A with services of an appropriate standard in December 1999 and January 2000, and June 2000 to September 2000. In particular:

- *Dr B inappropriately gave a sample pack of Aropax (paroxetine) to Miss A without adequately establishing the diagnosis of depression.*
- *Dr B inappropriately prescribed 20 tablets of lorazepam for Miss A for one flight to a new town.*
- *Dr B did not adequately involve Miss A's family in discussions about Miss A's diagnosis and treatment.*
- *Dr B inappropriately prescribed lorazepam concurrently with Sandomigran.*
- *Dr B inappropriately continued to prescribe Prozac (fluoxetine) for Miss A in combination with clonazepam, Clopixol, and Sandomigran (pizotifen).*
- *Dr B failed to recognise Miss A's adverse reaction to the drugs prescribed during the period June to September 2000.*

Dr B did not provide Miss A with sufficient information in December 1999 and January 2000, and June to September 2000. In particular:

- *Dr B did not explain the options available for treatment of flying phobia, anxiety and depression, including the option of behavioural therapy.*
- *Dr B prescribed 20 tablets of lorazepam for Miss A without explaining the risks of lorazepam, including tolerance and dependency.*
- *Dr B prescribed 20 tablets of lorazepam for Miss A without explaining the potential side effects of lorazepam, including depression and increased agitation.*
- *Dr B prescribed 20 tablets of lorazepam for Miss A without explaining the importance of restricting alcohol intake while taking lorazepam.*
- *Dr B did not inform Miss A of the adverse effects, and withdrawal symptoms, of the drugs he prescribed to her in June 2000 to September 2000.*

Information gathered

During my investigation I received information from Mrs A and Dr B. I also obtained independent advice from general practitioner Dr Caroline Corkill. A copy of Dr Corkill's advice is attached.

Dr B was Miss A's general practitioner from 31 January 1999 until late January 2000, when she moved from her hometown to the new town for several months, and from June 2000 until her death on 12 September 2000. Dr B provided me with Miss A's clinical records dating back to 8 January 1997. I note that Miss A consulted a different doctor at the same medical practice prior to 31 January 1999. These consultations occurred in 1997, 1998 and 1999 and were mainly in connection with prescriptions of Sandomigran for her migraines.

On 31 December 1999, Dr B recorded that Miss A had consulted him after having suffered an anxiety attack that day. She had experienced hyperventilation and carpopedal spasm. Dr B recorded that Miss A told him she was having symptoms of anxiety most days. While Dr B noted that there were no physical signs of depression, after establishing Miss A's situation and discussing recent past stressors with her, Dr B felt she was most likely also suffering from a degree of depression.

I note that Mrs A has advised the reason for the consultation that day was migraine and that Miss A did not have an anxiety attack until she arrived at Dr B's rooms.

Dr B considered that Miss A's anxiety symptoms were severe enough to warrant anxiolytic medication. He therefore prescribed a short course of lorazepam (20 x 500mcg tablets, two to four tablets to be taken three times daily if needed). Dr B advised me that he also spent some time explaining non-drug approaches to managing anxiety and depression, many of which Miss A was already aware. Dr B's notes from the consultation on 31 December 1999 record that Miss A had already tried meditation, but with no real effect. The notes record that Dr B discussed with Miss A using simple cognitive behavioural and relaxation techniques. He also discussed with her the possibility of starting on Aropax. Dr B advised me that he felt Aropax would be a good choice of antidepressant for Miss A because of its profile in aiding symptoms of anxiety as well as depression. Mrs A advised me that Dr B gave Miss A the starter pack of Aropax on this date although this is not recorded in his records.

Miss A returned to see Dr B on 17 January 2000, prior to moving to the new town to take up her tutoring position. Dr B recorded in Miss A's notes that she had had some benefit from the lorazepam, but that she was still at times really anxious. Miss A reported being very stressed about the possibility of having a panic attack on her forthcoming flight to the new town, and Dr B therefore repeated the lorazepam prescription to help with the journey.

The consultation notes for 17 January record that Miss A felt she would like to start Aropax. Dr B advised me that it was his usual practice when prescribing SSRIs (selective serotonin re-uptake inhibitors, such as Aropax) to explain that there is a delay before they are effective, but that they have long-term benefits in the control of anxiety and depression, rather than using solely benzodiazepines. Dr B advised me that he asked Miss A not to start taking Aropax until after she had flown to the other town, because he recognised that Aropax can initially make anxiety worse.

Dr B advised me that he felt strongly that Miss A needed a general practitioner in the new town, and that he impressed upon Miss A the importance of obtaining a GP as soon as

possible. The notes record that Miss A would be seeking out a GP once settled in this town.

Miss A's next consultation with Dr B was on 6 June 2000, after she returned to her hometown from the new town. Miss A told Dr B that she had attempted suicide the previous week, and that she had been admitted to a public hospital. Dr B recorded that Miss A had been commenced on 10mg daily of the anti-psychotic Clopixol, and that she was also taking 40mg a day of Prozac and 1mg of clonazepam twice a day. Miss A told Dr B she was not currently feeling suicidal. Dr B arranged to see Miss A on a weekly basis, and he referred her for urgent assessment by a mental health service.

At their consultation the following week, on 13 June 2000, Miss A reported that her week had not been too bad, and that she had been sleeping well although she had had some strange dreams. She reported having occasional thoughts of suicide but that her mood was fairly stable. On that occasion, Dr B and Miss A discussed her weight. Dr B noted Miss A was very thin. She told him that she had always been tall and thin and that as far as she was concerned her weight was definitely not an issue. Dr B noted that he would see Miss A again the following week, and that she had an appointment with the mental health service in two weeks' time.

When Dr B saw Miss A again on 20 June 2000, she reported feeling more settled and that her thoughts of suicide were less frequent. However, she told him that taking 10mg daily of Clopixol was making her feel very sleepy. Dr B therefore reduced the Clopixol dose to 5mg at night. He noted that she was seeing a psychiatrist on 3 July, and that he would see her again before then if necessary.

Miss A next consulted Dr B on 4 July 2000. She told him she had made superficial lacerations to her wrists the previous day, before her appointment with psychiatrist Dr C at another public hospital. Miss A told Dr B that she might be getting counselling through this hospital's alcohol and drug service as her father had a drinking problem when she was a child. She advised that Dr C had taken her off Clopixol and was weaning her off clonazepam. Dr B recorded in Miss A's notes that he and Miss A had had a long chat, and that he planned to continue seeing her weekly.

He saw her again the following week, on 10 July 2000, by which time Miss A reported that she was now living in her own home and was doing some tutoring work at home. She told him that she had slept poorly the night before and that she had suicidal thoughts which came and went. Dr B recorded in the notes that Miss A would be seeing Dr C in August, and that she did not want to see him the following week. He recorded the plan to reduce her clonazepam in 0.5mg increments.

Miss A's next consultation with Dr B was on 18 July 2000. She had run out of medication and Dr B wrote prescriptions for clonazepam and Sandomigran. By this time, Miss A had reduced her clonazepam to 1mg, but she told him she had felt anxious when she tried to reduce to 0.5mg. Dr B recorded in the notes that she would stay on 1mg for the following week, and then try reducing again.

Dr B advised me he was aware that Miss A was having problems reducing her dose of clonazepam. He considered this to be a combination of withdrawal effects and exacerbation of her anxiety. He advised me that on several occasions he discussed with Miss A withdrawal symptoms and how to handle them. I note Mrs A disputes that this could have occurred on several occasions, but acknowledges that it was discussed.

On 25 July 2000, Miss A consulted Dr B, reporting that she had attempted suicide the night before and that she had contacted the crisis team. Dr B recorded his impression that she was at high risk of suicide and that she needed close watching. He discussed her case with Dr C and the crisis team, which was to see her again that day. Miss A told Dr B that she preferred to see Dr C rather than anyone else. Miss A consulted Dr B on another two occasions before her death on 12 September 2000, once on 31 August 2000 after she spent the night in hospital having cut her wrists, and again on 7 September 2000 when she told Dr B she had been started on Epilim.

In relation to the aspect of the complaint that he did not adequately involve the family in discussions about Miss A's diagnosis and treatment, Dr B advised me that it was not his standard practice to discuss details of adult consultations with others.

Dr B noted that the combination of Prozac, clonazepam, Clopixol and Sandomigran had been initiated in the first public hospital when Clopixol had been added to her existing medication regime. He acknowledged to me that a combination of those medications could have an additive effect on the central nervous system and could enhance individual side effects. However, he stated that it was extremely common in medicine to prescribe combinations of medications that could interact and that serious interactions could be avoided by prescribing the lowest effective doses. Dr B considered the individual doses Miss A was taking were not large.

The Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights apply to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Independent advice to Commissioner
The following expert advice was obtained from Dr Caroline Corkill, general practitioner:

"I am a general practitioner in Invercargill. I have been asked for independent advice in this complaint against two general practitioners and their management of a young woman who subsequently committed suicide.

I have been sent and have read the following:

- A copy of the Commissioner's notification of investigation to [Dr B] dated 14 August 2002, marked 'A'.
- A copy of [Dr B's] response to the Commissioner's investigation dated 1 September 2002, and attachments, marked 'B'.

These attachments included an earlier letter of response from [Dr B] received by your office on 23 July 2002, a copy of the computer notes regarding [Miss A] from [the medical centre] where [Dr B] works including copies of blood test results, [Dr B's] letters to ACC dated 23 May 2001, a To Whom It May Concern letter regarding [Miss A] dated 25 August 2000, a letter referring [Miss A] to the [mental health service] on 8 June 2000, and copies of 10 pages of information from [the second public hospital] – 3 from an acute admission at the time of an episode of wrist slashing on the 31 August 2000, a one page letter after being seen by a psychiatrist, [Dr C], on the 27 July 2000, a four page Psychiatric assessment by [Dr C] after slashing her wrists on the 3 July 2000 and the two pages of crisis team notes from that date. There are also five pages of notes from [the first public hospital] regarding assessments on 24 May 2000 and 30 May 2000.

The particular questions asked of me about the complaint against [Dr B] are:

1. Please comment on the allegation that it was inappropriate for [Dr B] to give [Miss A] a sample pack of Aropax (paroxetine) without adequately establishing the diagnosis of depression. Do I consider this prescribing to be inappropriate?
2. Please comment on the allegation that it was inappropriate for [Dr B] to prescribe 20 tablets of Lorazepam for one flight to [the new town]? Do I consider this prescribing to be appropriate?
3. Please comment on the allegation that [Dr B] did not adequately involve [Miss A's] family in discussion about [Miss A's] diagnosis and treatment. In what circumstances is it appropriate to involve family?
4. Please comment on the allegation that [Dr B] inappropriately prescribed Lorazepam concurrently with Sandomigran. Do I consider this prescribing to be appropriate?
5. Please comment on the allegation that [Dr B] inappropriately continued to prescribe Prozac in combination with clonazepam, Clopixol, and Sandomigran. Do I consider this prescribing to be appropriate?
6. Please comment on the allegation that [Dr B] failed to recognise [Miss A's] adverse reaction to the drugs prescribed during the period June to September 2000. What evidence is there of adverse reaction?
7. What options should a reasonable general practitioner provide/explain for treating flying phobia, anxiety and depression?

8. What information should a reasonable general practitioner provide about the risks of Lorazepam?
9. What information should a reasonable general practitioner provide about the potential side effects of Lorazepam?
10. When a person is prescribed Lorazepam, what information should a reasonable practitioner provide about alcohol intake?
11. What information should a reasonable general practitioner provide about the adverse effects, and withdrawal symptoms, of Prozac, clonazepam, Clopixol, and Sandomigran?

Overall, do I consider that [Dr B] provided [Miss A] with an appropriate standard of care? Please comment on any other matter I consider relevant.

My answers are as follows:

1. In my opinion, Aropax (paroxetine) is the drug of choice for anxiety based depression. It is common practice to start this drug by giving a patient a sample pack to try before reporting back as to how it is going. I notice from [Dr B's] notes that he discussed [Miss A's] symptoms of anxiety and possible depression on the 31 December 1999, he recorded that they discussed her mood, some of the things that had been happening in her year and her plans for the immediate future. He noted 'no physical signs of depression' at that consultation, but there may have been some symptoms. I also noted a comment by one of the psychiatrists who assessed [Miss A] later, [Dr C], who said 'the reported mental condition is out of keeping with her general presentation and behaviour.' [Dr B] gave [Miss A] a prescription for a short course of lorazepam on 31.12.99, and suggested she try reading and relaxation techniques. It was over two weeks later that he gave her the sample of aropax and I note he records the suggestion she start with 10mg a day which is half a tablet (half the standard dose) which is a good careful way to start this drug in someone who is prone to anxiety, and suggests she delay starting it till she has flown to [the new town]. I consider this prescribing to be appropriate.

2. 20 tablets of lorazepam 500mcg were prescribed on the 31 December 1999 and found to be helpful for [Miss A's] anxiety attacks so [Dr B] repeated this prescription on the 17 January 2000 before she flew to [the new town]. I think this is appropriate treatment for anxiety. The twenty tablets were for the flight and for other episodes of anxiety. It was a quicker way of dealing with the anxiety before the flight than waiting for the aropax to become effective. 20 is not very many – especially when you realise the lowest dose now available is twice the strength he was prescribing. I would use 1-2 tablets of the 1mg as needed, which is the equivalent of what he gave [Miss A], but the smaller dose gives the patient more options for using less at each occasion if they want to.

3. The allegation that [Dr B] did not adequately involve [Miss A's] family in discussions about [Miss A's] diagnosis and treatment is unfounded in my opinion. At the time of the initial prescribing of lorazepam and aropax I think it would have been extremely unusual to involve the patient's family unless the patient had brought

family along to the consultation with her and wanted them involved. It can be very difficult to know whether family involvement for an adult patient with mental health issues is going to be helpful or counterproductive. It is appropriate to involve family if the patient is a young person and under the legal care of the family, but still only if the general practitioner thinks there is a risk of serious and imminent danger to the patient or other members of the community. With adults it is more common, and in my opinion safer, for a general practitioner to involve other help, for example the local mental health team, rather than family. [Dr B] involved the local mental health team appropriately.

4. In a patient who has been on sandomigran for migraine prevention, I do not think prescribing concurrent lorazepam is inappropriate. It is possible that the combination may lead to some extra sedative effect, but sedation is a variable effect of each of these drugs on its own and together, depending on the person taking them.

5. I think it is appropriate to continue prescribing prozac in combination with clonazepam, clopixol and sandomigran, especially when a more specialised doctor in mental health has started some of these drugs and left the combination together. I think what [Dr B] did in reducing the dose of clopixol when [Miss A] complained of sedation was appropriate. Clopixol is an antipsychotic agent which is usually prescribed by psychiatrists, very rarely by general practitioners. It is not subsidized and was started by the mental health team in [the first public hospital] just before [Miss A] returned to [her hometown].

6. I see no evidence to support the allegation that [Dr B] failed to recognise [Miss A's] adverse reaction to the drugs prescribed during the period June to September 2000. I have not seen anything describing [Miss A's] mood or behaviour other than medical records over that time. [Dr B's] notes record [Miss A] reporting improvement in her symptoms eg 13 Jun 2000 'Week hasn't been too bad. Sleeping well although has had some strange dreams ….' Strange dreams could be thought to be a reaction to medication, part of the mental health problem in the first place, or part of getting better. A week later, 'Feeling more settled … but very sleepy.' This is [Dr B] recognising an adverse reaction to medication and so he reduces her clopixol, notes she is going to be reviewed by the Psychiatrist on the 3 July, and arranges to see her in between if necessary. I consider this to be appropriate treatment by the general practitioner.

7. Some of the options a reasonable general practitioner might discuss for treating flying phobia, anxiety and depression include, relaxation techniques, distracting techniques, counselling, exercise and medication. From [Dr B's] notes on the 31 December 1999 it seems as though he did discuss some of these. Often these discussions are not recorded in anything like the detail which the conversation covers – if it did – general practitioners would not have the time to discuss the options.

8. The information a reasonable general practitioner would probably provide about lorazepam is that it is a useful, short-acting anti-anxiety agent. Most GPs explain

that we only use it in small amounts and for short periods because it can lead to tolerance or dependence. It can make some people sleepy and so it is important to use it with care when you are using other medication or alcohol, which can aggravate the sedation. The pill container usually also has this written on it by the chemist. Most reasonable GPs would not record that they had given that information to a patient because it would take too long and as I said in the previous question, make it harder to spend time explaining to the patient. There is also a rare risk of agitation, which I only remembered about when reading up about these drugs for writing this opinion. I do not think this potential risk is common enough to routinely warn people about before they take lorazepam.

9. As in question 8. I think most general practitioners think of the risks and the potential side effects as being similar things.

10. As in question 8, this is usually covered in the same explanation, and as I stated in 8, the chemist usually reinforces the message about lorazepam and alcohol. There is a problem with this in that a patient might disregard the advice or not consider it applies to them for whatever reason. Even reasonable general practitioners sometimes forget to give all the possible warnings about concurrent drug and alcohol use, which is why the chemist warning is a good idea.

11. A reasonable general practitioner should advise patients before they start them on a new drug – for Prozac the main warning is that other people who hear about them taking this drug will often try and talk them out of taking it because of the mixed messages in the media about it. It is worth saying some people get tremor, headache or nausea from it so it is best taken in the morning with food. This drug was started by a general practitioner in … and I consider it his responsibility to have given this information. Clonazepam is a long-acting anti-anxiety agent in the benzodiazepine family like lorazepam. It has side effects of sedation and a risk of dependence but is used in cases like this where the anxiolytic is being used for some time as it has a lower risk of addiction/dependence than the quicker acting lorazepam. Again, this drug was started by another GP whose responsibility it was to explain this. Clopixol is an anti-psychotic drug which I have not come across in general practice before reading this complaint. It is a member of the thioxanthene family which all have the potential to cause a variety of side effects including sedation, unwanted movements and interactions with other medication – I think it was the responsibility of the [first public hospital's] mental health team to explain this, but that may have been difficult as it is used in states of extreme anxiety when often a patient is not fully able to grasp and remember potential risks and side effects. Sandomigran's main side effect is one of weight gain which does not seem to have been a problem for [Miss A]. This should have been explained to her when she started it, and the fact that it can be very effective in reducing the frequency and severity of migraines. It does have a small sedative effect but for most people it is the weight gain which is the main disadvantage of the drug.

Overall I consider [Dr B] provided [Miss A] with an appropriate standard of care."

Commissioner's Provisional Opinion

Inappropriate prescribing of Aropax
In relation to Dr B's diagnosis of depression, Dr Corkill noted that on 31 December 1999 he and Miss A had discussed her general mood, some of the events she had experienced during the year, and her plans for the immediate future. Dr Corkill observed that while Dr B noted there were "no physical signs of depression", there may have been other signs of depression.

Dr Corkill advised me that in her opinion Aropax is the drug of choice for anxiety-based depression. She advised me that giving a patient a sample pack to try is common practice. She noted that during their discussion on 17 January 2000, when Dr B and Miss A discussed her commencing on Aropax, he recommended she wait until after the flight to the new town before starting it, and he recommended she start on 10mg daily, which is half the standard dose. In someone prone to anxiety, Dr Corkill considered this was a "good careful way" to start Aropax.

Dr Corkill considered Dr B's prescribing of Aropax appropriate, and I accept that advice.

Inappropriate prescribing of lorazepam
In Dr Corkill's opinion, it was also appropriate for Dr B to prescribe 20 x 500mcg tablets of lorazepam on 17 January 2000. She noted that the tablets were prescribed not only for the flight, but to help Miss A with the journey to the new town and for other episodes of anxiety. Miss A had reported that the lorazepam Dr B prescribed for her on 31 December 1999 had been helpful for her anxiety.

Dr Corkill noted that the lowest dose of lorazepam now available is twice the strength Dr B prescribed. She advised me that she would prescribe 1-2 tablets of the 1mg dose as needed, and that this was the equivalent of what Dr B prescribed for Miss A. Dr Corkill also commented that 20 tablets were not very many, and that lorazepam was a quicker way of dealing with Miss A's anxiety about the flight to the new town than waiting for Aropax to become effective.

Inadequate family involvement
Dr B advised me that it was not his standard practice to discuss details of adult consultations with others. Dr Corkill considered it would be extremely unusual for a general practitioner to involve an adult patient's family, unless the patient had brought the family to the consultation or wanted the family to be involved. Dr Corkill considered that Dr B's involvement of the local mental health team was appropriate. I accept that advice and in my opinion it would have been inappropriate for Dr B to have involved the family in Miss A's treatment, unless Miss A had specifically requested him to do so.

Inappropriate prescribing of lorazepam concurrently with Sandomigran
Dr Corkill advised me that it was possible that the combination of lorazepam and Sandomigran could lead to some extra sedative effect. The sedative effect of the two medications, taken on their own or together, would vary depending on the person taking them, she advised. However, Dr Corkill did not consider it was inappropriate to prescribe lorazepam to a patient who was on Sandomigran for migraine prevention, and I accept her advice.

Inappropriate prescribing of medications in combination
Dr Corkill considered it appropriate for Dr B to continue prescribing the combination of Prozac, clonazepam, Clopixol and Sandomigran. She noted that this was especially the case as some of the medications had been commenced by the psychiatrist Miss A saw at the first public hospital. It is common practice for a general practitioner to continue prescribing medication initially commenced by a specialist in the field. Dr Corkill considered Dr B acted appropriately in reducing Miss A's dose of Clopixol when she reported that it made her sleepy, and I accept that his actions were appropriate.

Failure to recognise adverse drug reactions
Dr Corkill could see no evidence that Dr B failed to recognise any adverse drug reactions. With regard to Miss A reporting that the Clopixol made her sleepy, Dr Corkill advised me that Dr B acted appropriately in reducing the dose and arranging to see Miss A if necessary before she was reviewed by Dr C.

Insufficient information about treatment options
Dr Corkill considered that some of the options a reasonable general practitioner might discuss for managing flying phobia, anxiety and depression, included relaxation techniques, distracting techniques, counselling, and exercise. She noted that Dr B had recorded in Miss A's notes discussing some of these options with her. Dr Corkill commented that general practitioners do not generally record anything like the detail discussed with patients. She observed that if they did, they would not have time to discuss the options. I accept that Dr B discussed a variety of treatment options with Miss A, and while he did not record all the details in the notes, in my opinion there is no evidence to suggest that Dr B did not provide Miss A with sufficient information.

Insufficient information about lorazepam – risks, side effects, importance of restricting alcohol intake
Dr Corkill advised me that most general practitioners would explain to a patient that lorazepam is a useful, short-acting anti-anxiety agent, and that it is only prescribed in small amounts for short periods because it can lead to tolerance or dependence. Dr Corkill advised me that lorazepam can make some people sleepy and that it is important to take care with it when using other medications or alcohol, which could aggravate the sedative effect. She noted that pharmacists usually reinforced the importance of restricting alcohol intake with lorazepam, which she considered a good idea as even reasonable general practitioners sometimes forgot.

Dr Corkill advised me that most reasonable general practitioners would not record all the information they had given a patient, again because it would take too long and make it

harder to spend time with the patient. Dr B advised me that, while not stated in his notes, it is his usual practice to explain the use of medications he prescribes, their common side effects and their interactions with any other drugs. I accept that Dr B gave Miss A sufficient information about lorazepam.

Insufficient information about adverse drug effects/ withdrawal symptoms
Dr Corkill advised me that patients should be given appropriate information before being started on new medications. Dr Corkill noted that Prozac and clonazepam had been started by Miss A's general practitioner in the new town and that it was therefore his responsibility to provide adequate information about those medications.

In Dr Corkill's opinion, the main warning with Prozac is that other people might try to talk the patient out of taking it because of the mixed messages in the media. She advised me that, as Prozac gave some people tremor, headache or nausea, it was better taken in the morning with food. In relation to clonazepam, Dr Corkill advised me that a reasonable general practitioner might convey that it is a long-acting anti-anxiety agent in the benzodiazepine family, like lorazepam. She advised me that it was an anxiolytic prescribed over longer periods of time than lorazepam, because the risk of addiction/dependence is lower than with the quicker acting lorazepam.

Dr Corkill noted that Miss A had been started on Clopixol by the psychiatrist at the first public hospital who was therefore responsible for explaining the drug to her. She noted that Clopixol is prescribed to patients who are in a state of extreme anxiety, which means that patients often do not grasp fully or remember what they are told about its potential risks and side effects. Dr Corkill advised me that Clopixol is an anti-psychotic drug which she had not come across before in general practice. As a member of the thioxanthene family, it had the potential to cause a variety of side effects including sedation, unwanted movements and interactions with other medications.

Dr Corkill advised me that the main side effect of Sandomigran is weight gain, which should have been explained to Miss A when she started it. She advised me that Sandomigran does have a small sedative effect, but for most people weight gain is its main disadvantage.

I accept Dr Corkill's advice that the original prescriber of medications is responsible for explaining the medications' risks and benefits, adverse effects and withdrawal symptoms. Dr B advised me he was aware that Miss A was having problems reducing her dose of clonazepam, which he considered to be a combination of withdrawal effects and exacerbation of her anxiety. He advised me that he discussed with Miss A withdrawal symptoms and how to handle them on several occasions. In my opinion, he acted appropriately in so doing.

Summary
Dr Corkill advised me that Dr B provided Miss A with an appropriate standard of care. His initial prescribing of Aropax and lorazepam was appropriate, and his continued prescribing of Miss A's medications when she returned to her hometown from the new town was also appropriate. Dr Corkill did not consider that Dr B had failed to recognise adverse drug

reactions in Miss A, and she advised me that he acted appropriately in reducing her Clopixol dose.

Dr Corkill informed me about the information that a reasonable general practitioner should provide patients about treatment options and the medications they are being prescribed. She advised me that a reasonable general practitioner would not record all the details of the information provided. Otherwise, they would not have time to discuss the information with the patient. I have no reason to believe that Dr B did not provide that information to Miss A.

I am guided by the advice of my independent general practitioner advisor. I accept her advice that Dr B provided Miss A with an appropriate standard of care, and in my opinion he did not breach Right 4(1) of the Code. I also accept that, while he has not recorded all the details, Dr B provided Miss A with sufficient information about treatment options and the medications she was prescribed. Therefore, in my opinion Dr B did not breach Right 6(1) of the Code.

Response to Commissioner's Provisional Opinion

Mrs A supplied extensive information responding to my provisional opinion that Dr B did not breach the Code. I forwarded the information to my advisor, Dr Caroline Corkill, for further comment and also to ascertain whether any of the material Mrs A supplied changed my advisor's view.

Further advice to Commissioner

Dr Corkill's further comments made in response to questions put to her are outlined below.

1. *Mrs A refers to a number of documents in her response including documentation compiled by the National Health Committee such as "Guidelines for assessing and treating Anxiety disorders" and "Guidelines for the treatment and management of depression by primary healthcare professionals". Please comment on the use of guidelines such as these in general practice generally, and advise whether you would expect general practitioners to follow specific treatment steps outlined in these documents.*

   "'The Guidelines for assessing and treating Anxiety disorders' and 'Guidelines for the treatment and management of depression by primary healthcare professionals' are part of a growing number of guidelines developed in New Zealand by various bodies (National Health Committee, Royal New Zealand College of GPs, Ministry of Health etc) and posted to General Practitioners to inform us of what are considered the appropriate ways to diagnose and treat various conditions. They are **guidelines** not protocols, and have been met with a variety of responses from complete lack of interest to some support. I think they are a helpful resource, but often long-winded (though most come with a summary form). In my experience they are not referred to often. I was sent three copies of the one on Depression in August 1996 and was not sent the one on Anxiety, so ordered it to better understand [Mrs A's] comments. In practice,

doctors do not follow guidelines quite the way flowcharts make it seem as though they should, because every case is different and sometimes you are trying to work out which set of guidelines would be applicable for a particular patient. There is useful information in most of the guidelines but there is not always time to check them, nor do we always remember which topics there are guidelines for. In short, most of these guidelines are not referred to often."

2. *Does any of the information supplied convince you that there was insufficient evidence to indicate that Miss A was anxious enough to require medication at the time of her initial consultation with Dr B?*

"[Dr B's] notes regarding [Miss A] on the 31.12.99 are good notes in my opinion. They contain a presenting complaint or reason for the consultation – that is 'Anxiety attack today', some notes about what was discussed, including reference to what had been going on recently that might have contributed to anxiety, some objective measurement as in the blood pressure and a comment about lack of objective signs of depression, 'No physical signs of depression'. This is an observation of the doctor's and does not rule out **symptoms** (contrary to [Mrs A's] comment in paragraph 12) of depression, which are the subjective side of illness. There is mention of a plan of action and a possible explanation of what was happening. I think this shows a lot was covered in a general practice setting where usually 10-15 minutes is allowed for each appointment. Often consultations where there is a lot of talk about feelings and concerns take longer than this and in many cases the notes suffer. It is possible other things were discussed and have not been recorded. These notes reflect at least adequate discussion of anxiety attacks and their possible relationship to depression. I think it was reasonable to discuss possible use of an antidepressant like Aropax at this time and to give the patient a prescription for 20 0.5mg tablets of lorazepam. I see the notes record mention of reading and trying relaxation technique(s). [Mrs A] seems to have a preference for non-medical treatments of symptoms like anxiety, but the psychotherapeutic techniques listed in the Guidelines on Anxiety are not part of what most general practitioners are trained to do.

It is not necessary to confirm a diagnosis of Generalised Anxiety Disorder the first time you see someone, nor is it necessary to make this diagnosis before offering someone medicinal help for any problems with anxiety. I accept [Mrs A's] point that some anxiety is normal and certainly not all requires medication. I would suggest that an anxiety attack that goes as far as carpopedal spasm (where hand and foot muscles go into spasm from hyperventilation) is a reasonably severe manifestation of anxiety. It is not usually part of mild anxiety. [Dr B's] notes do record, 'may have mild depressive illness and **anxiety**,' not **mild anxiety**."

3. *Was there insufficient evidence that Miss A was depressed enough to require medication?*

"I think there was sufficient evidence that [Miss A] was depressed enough to require medication, [Mrs A] thinks there was not and [Dr B] thinks there was. The medical notes do not contain a checklist of symptoms and signs of depression which would be

helpful for both [Mrs A] and me, but the reality is General Practice notes often do not list all the things the GP is considering, especially when things like depression are being discussed. The notes say 'chat re depression' which I take to mean they spoke about possible symptoms and solutions, probably in a general way that did not say to [Miss A] that she was depressed, but so they both knew it was a possibility. As I said before, I think the degree of anxiety [Miss A] was reported in the notes to be suffering from would warrant consideration of treatment with medicines. In [Dr B's] notes he says she had tried meditation with no real effect, and he does refer to relaxation techniques. If someone is getting relief from lorazepam and needing it more than once or twice a month I think it advisable to use a longer acting anxiolytic, usually this means using an antidepressant, and Aropax is the most commonly used of these now for these sorts of symptoms. [Dr B's] notes of 31.12.99 do mention discussion of cognitive behavioural techniques – 'Chat re anxiety and managing it with simple cog-Behavioural techniques' which is considered one of the most useful forms of non-pharmacological therapy, which I think shows he has considered the possibility of using non-pharmacological treatments, but as I said in the previous answer (2) most GPs are not trained to do that so possibly we do resort to pharmacological treatments more readily than some people would like us to."

4. *Is there evidence to support Mrs A's belief that Miss A's only initial problem was headaches/migraine? Please comment on Mrs A's statement that migraine symptoms can mimic anxiety?*

"There is no evidence other than [Mrs A's] word that [Miss A's] only initial problem was migraine. There is no mention of it in the notes from Dec 99 and Jan 00, but as I have said before, things which are not recorded in the notes may well have been discussed. I agree with [Mrs A] there is overlap between headaches and anxiety but the clinical presentation of migraine and that of anxiety attacks is quite different in my experience. The numbness and paraesthesiae of migraine is usually unilateral whereas that of anxiety attacks is usually bilateral. Carpopedal spasm is usually bilateral and would only be present with a migraine if the migraine itself triggered anxiety and hyperventilation, which is possible but unusual in my opinion. It seems from the notes that [Dr B] considered anxiety attack the main problem on the 31.12.99."

5. *Please comment on any inherent dangers of the drug Aropax, with reference to the concerns Mrs A has outlined about it.*

"There are inherent dangers in all drugs. Drugs used to affect the central nervous system often have side effects on that system – so of course there are inherent dangers in using Aropax. [Mrs A] lists them from the Medsafe data sheet in paragraph 24, 'the most commonly observed adverse effects … nausea, somnolence, sweating, tremor, asthenia, dry mouth, insomnia, sexual dysfunction, dizziness, constipation, diarrhoea and decreased appetite', and then the rare ones. Doctors are aware of these possible side effects but have to decide which of them it is reasonable to warn people about because it can be hard to predict which may happen, and yet telling patients about the whole list is overwhelming. We always have to balance the possible good and bad caused by a drug and include the patient in that decision. The side effects I usually

mention as possible with Aropax are the nausea, tremor and sleep disturbance because they seem to be the most common. I do not know which possible side effects [Dr B] and [Miss A] discussed because it is not recorded, but I do not consider that [Dr B] took unreasonable risks in prescribing either the lorazepam or the Aropax – they are both the drugs I may well have used in the situations described in his notes of the 31.12.99 and 17.1.00, separately or together. Despite the possible side effects of Aropax (an SSRI) which [Mrs A] quotes, the PreMeC overview of antidepressants in November 2002 says 'Newer antidepressants (including SSRIs) have significant safety and tolerability advantages over the first generation tricyclic agents.' The latter were the medicines previously used by doctors in cases of anxiety and depression. The other bulletin released that month by PreMeC said:

- 'SSRIs are now the first line pharmacological treatment for depression in primary care.
- SSRIs have proven efficacy in mild to moderately severe depression
- SSRIs are generally well tolerated and safe medications for the treatment of depression'."

6. *In your view, did Dr B take insufficient steps to ensure Miss A was monitored once she was on medication he had prescribed?*

"In my view [Dr B] took sufficient steps to ensure [Miss A] was monitored once she was on medication. I think the steps he took – of suggesting she start on a low dose (l0mg Aropax is half the usual starting dose) after the plane trip, of asking her to find a GP in [the new town] and of giving her some lorazepam to take as needed for anxiety were reasonable steps. I do not think withholding the paroxetine/Aropax because she was leaving town would have been any safer or better. I think it was reasonable to repeat the script for lorazepam in the circumstances even though it meant her having these pills for more than two weeks – the suggestion of two weeks taking a benzodiazepine and two weeks coming off is a guide not a rule and generally refers to regular use rather than episodic use. The responsibility for monitoring a medication is a combined one in my view – it involves teamwork between doctor and patient and this is difficult in someone who is moving from one place to another and changing doctors. As I said before, I think [Dr B] took reasonable steps to ensure [Miss A] was being 'monitored' with these drugs. I accept that [Mrs A] disagrees with me."

7. *Please clarify the following comment that you made in response to Question one of your original advice about Dr B:*
"[Dr B] noted 'no physical signs of depression' but there may have been some symptoms."

"The difference between symptoms and physical signs is one doctors use to differentiate between what a patient notices or reports (symptoms) and what the doctor observes (signs). Physical signs include objective things like jaundice, anaemia, obesity, flat affect, restlessness etc. In other words, just because [Dr B] says 'no physical signs of depression', it doesn't mean that [Miss A] wasn't depressed, it means she didn't look sad or depressed at the time (something [Dr C] also mentions later on in her full psychiatric assessment)."

8. *On 31/12/99, Dr B noted in his records that Miss A "may have a mild depressive illness". On the same date, he also recorded "No physical signs of depression". Is this contradictory?*

   "Similarly when [Dr B] says 'may have mild depressive illness' and 'No physical signs of depression' it is not contradictory – it could mean she is telling him things that may indicate depression even though she may not look depressed."

9. *When Miss A first presented on 31/12/99, should initial treatment have been delayed in order to further clarify the diagnosis?*

   "As I have said before anxiety with carpopedal spasm usually indicates severe anxiety and I think it was reasonable for [Dr B] to offer medical treatment, even though [Mrs A] disagrees. I do not think there even had to be a diagnosis of GAD (generalised anxiety disorder) to treat the episodic anxiety. Other pathological anxiety can also be treated with lorazepam. I think it was appropriate to use short term medication first, get [Miss A] back to review how she was going and see if the proposal to use a longer acting anti-depressant was going to be a good idea."

10. *Is there any evidence that Miss A suffered from initial isolated panic attacks, but did not have an anxiety or panic disorder which was severe enough to require medication?*

    "It is possible that initially [Miss A] suffered from isolated panic attacks but from [Dr B's] notes of the 31.12.99 it sounds as though the underlying stress and anxiety was more than that. 'General non-specific anxiety most days' '++stress' '++air travel that made her very anxious' In my experience people do not usually consult a doctor about anxiety unless it is becoming unmanageable for them."

11. *Please comment on the claim that the dose of Lorazepam that Dr B prescribed to Miss A was not low, and the claim that Lorazepam is "extremely potent" as it is up to 10 times the strength of diazepam (Valium)?*

    "[Mrs A] quotes extensively from studies in the 1980s when the use of benzodiazepines was more prevalent than it is now. Doctors then were only learning of the addictive nature of benzodiazepines and [Mrs A] rightly points out some of the dangers with these drugs. In my experience most doctors these days (and in 1999) are aware of these risks and so use benzodiazepines more cautiously. I said before that the dose of lorazepam [Dr B] prescribed was appropriate. I did not say it was low, but pointed out the dose my colleagues and I use now is usually around 1-2mg as needed, up to three times a day. What he prescribed was exactly that, but using the 0.5mg tablets which are no longer available. That does give a maximum of 6mg daily possible but with a total of 20 pills (10mg) to be used in several weeks it showed he did not expect [Miss A] to be using them every day or at that level, in fact with 20 tabs using them 2-4 as needed would have only given her 5-10 doses. There is a difference between the strength ('anxiety relieving activity' as [Mrs A] calls it) of lorazepam and diazepam milligram for milligram with lorazepam thought to be 5-10 times more potent than diazepam. This is reflected in the different strength tablets available – lorazepam comes in 1mg and 2.5mg

and diazepam in 2, 5 and 10 mg tablets. The main difference between these two in practice is their half life, lorazepam having a shorter half-life than diazepam, which means it works quicker, wears off quicker, and is thought to be more likely to lead to dependence than diazepam (although they both can)."

12. *Please refer to the information Mrs A has supplied which states that Benzodiazepines should only be used short-term. Please comment on this and advise whether, in your opinion, Dr B should have stopped Miss A's benzodiazepines sooner?*

"I agree with [Mrs A's] information stating that benzodiazepines should only be used short-term and on an intermittent, as needed, basis. I think that is what [Dr B] intended. The 'prn' on his prescriptions translates to 'as needed' which is what doctors write if they want the drug to be taken as required instead of regularly. Repeating the prescription for 20 lorazepam does not mean he was supporting its use long-term. I think it was reasonable to give [Miss A] another prescription for 20 0.5mg tablets before her move to [the new town]."

13. *Please comment on any inherent dangers of Lorazepam, with reference to the concerns Mrs A has outlined about it.*

"I agree with [Mrs A] there are inherent dangers in the drug lorazepam, as I said in the answer to question 5, there are dangers in all drugs. In lorazepam, as with all benzodiazepines, there is a risk of dependence, rebound anxiety or withdrawal symptoms, it potentiates the effects of alcohol and in overdose produces drowsiness, disorientation and muscle weakness (I quote from the Guidelines for Assessing and Treating Anxiety Disorders which [Mrs A] also uses). I think the cases [Mrs A] cites in paragraphs 83 and 84 are extreme examples of one view of benzodiazepines – ie the view that their side effects outweigh their benefits and they should never be used. However, they are also the quickest acting antianxiety agents, and if used appropriately are very useful for this, which is why general practitioners, psychiatrists and anaesthetists still use them."

14. *Does any of the information Mrs A has supplied about the benefits of involving family in mental health patient's treatment change your opinion about the appropriateness of Dr B's actions at the time?*

"As a mother I can understand [Mrs A's] wish to have been more involved in her daughter's care, but as a general practitioner it is very difficult to know how and when to involve family in the care of a young adult patient. Patients who want their family involved sometimes bring them along with them and families who want to be involved sometimes bring their family member to the doctor. If you are the doctor and do not know what the relationship is like between the patient and her family, it is my opinion you are safer to try and involve other professional support systems like the local mental health team. I think [Dr B] did this at the appropriate time in his care of [Miss A], that is, when she came back from [the new town]. I know how difficult it can be to get patients to talk about their health with family members especially if it involves mental health problems, so even if [Dr B] had wanted to it might not have been feasible, he is

certainly not permitted to tell family about the patient's problems if the patient doesn't want them to. Except of course in the circumstances that [Mrs A] refers to where 'unauthorised disclosure' is permitted, that is, 'When the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to –
(i) public health or public safety
(ii) the life or health of the individual concerned or another individual …' Health Information Privacy Code.

The difficulty still facing a doctor like [Dr B], if he thought [Miss A's] life or health was under 'serious and imminent threat' was who it was most helpful (for [Miss A]) for him to tell. For a young adult, I think most doctors would choose a local specialist mental health team, for an adolescent the family might be considered the ones to tell."

15. *Does any of the information Mrs A has provided about the effects of Lorazepam and Sandomigran's effects change your opinion that it was not inappropriate to prescribe these drugs concurrently?*

"No. I stand by what I said in my earlier letter, that it is possible there might be some extra sedative effect but that would not stop me prescribing lorazepam and sandomigran concurrently."

16. *Does any of the information Mrs A has provided about other drug combinations change your opinion that it was not inappropriate to prescribe these drugs concurrently?*

"I think this question now refers to [Dr B's] continuing to prescribe medication which had been started by the mental health specialists in [the new town]. This is always an awkward phase of treatment for a General Practitioner – we tend to assume the mental health team is more expert than us in its diagnostic ability for mental health problems and more skilled in choosing the right medication. It would be a brave general practitioner who stopped or changed any therapy suddenly at this point. I accept [Mrs A's] comments about the dangers of multiple drug use in paragraphs 144-157 but would like to point out that sometimes multiple drug therapy is used. I do stand by what I said about [Dr B's] actions in continuing the medication from [the first public hospital] as being reasonable. There is a big jump from prescribing lorazepam (as needed) along with sandomigran and low dose Aropax as [Miss A] was advised by [Dr B] in Jan 00, to prescribing daily Prozac 40mg, sandomigran, clonazepam and clopixol (a specialist only drug). I think [Dr B] took appropriate action when he saw [Miss A] on 6 Jun 00 by 'Plan weekly meeting. Weekly script for clonaz. Refer for urgent assessment base.' I think this showed he recognised [Miss A] needed specialist care, and showed he was using appropriate management until the local mental health team could see her."

17. *Based on Miss A's medical records, is there any evidence that Miss A suffered from any of the adverse drug effects that Mrs A has mentioned in paragraphs 163-173. If so, should Dr B have taken any action in response to them?*

"From [Miss A's] medical records we can see that there is evidence of some of the adverse effects [Mrs A] talks about including suicide attempts, strange dreams, sleepiness, anxiety. There is controversy as to whether these are more likely to be the result of medication or the result of the illness leading to the use of medication. Although [Mrs A] highlights that Prozac should be used with caution in those with suicidal tendency, some psychiatrists maintain using SSRIs in these patients is safer than most alternatives because it is such an effective antidepressant usually and safer in event of overdose. (eg Prof Pete Ellis, Dept of Psychological Medicine, Wellington School of Medicine) As far as side effects like sedation, this is not evident in the notes until 20 June 2000 when [Dr B] takes appropriate action by reducing the daily dose of clopixol. If there were withdrawal effects of the benzodiazepines they are not specifically mentioned but the fact that [Miss A's] doctors kept prescribing them and at some visits suggesting their use was reduced shows they were aware there could be withdrawal effects if this was not done gradually. [Mrs A] says her lists of side effects from the Medsafe data sheets are the ones [Miss A's] notes contain, but then lists many symptoms that have not been mentioned in any notes I have seen. I notice she refers to her letter to the Commissioner of 27 May 2003 which I have not seen unless that is the booklet, 'Finding Answers and Reaching Understanding of the Anxiety State, Medication and Suicide'."

18. *Does any of the information Mrs A has supplied about benzodiazepines, or lorazepam specifically, change your opinion about the information that should have been provided to Miss A about the risks of the drugs, tolerance or dependency?*

"Back to the beginning again. I have supported [Dr B's] use of lorazepam. We do not know what he said to [Miss A] about the use of this medication. He has not recorded that information in the notes and I find that quite usual in this situation. He has chosen medication appropriately and used an appropriate amount to be taken 'as required'. I accept most of the comments [Mrs A] makes about benzodiazepines, but the comments she quotes are mostly referring to regular, not as required, use of the drug. Most doctors know there are problems with benzodiazepines and generally use them carefully. There is no evidence that [Dr B] is doing other than this. [Mrs A] obviously disagrees with my opinion about this use of lorazepam – paragraphs 216-220. I stand by my comments."

19. *Does any of the supporting documentation that Mrs A supplied with her letter dated 12 June 2003 alter your opinion that Dr B provided Miss A with a reasonable standard of care?*

"None of the supporting documentation supplied by [Mrs A] with her letter dated 12 June 2003 alters my opinion that [Dr B] seemed to provide [Miss A] with a reasonable standard of care."

In answer to the additional points raised by Mrs A and referred to on page 4 of her letter.

1. *Mrs A has advised that Dr B gave Miss A a starter pack of Aropax at their first consultation on 31 December1999, although she did not take any until after their*

second consultation on 17 January 2000. Does this change your advice about whether the prescribing of Aropax was appropriate?

"[Mrs A] advised that [Dr B] gave [Miss A] a sample pack of Aropax at their first consultation on 31 December 1999 although she did not take any till after their second consultation on the 17 January 2000. This does not really make sense but does not change the appropriateness or safety of the drug's use which I have already commented on. It would make more sense that [Dr B] gave the sample pack to [Miss A] when she came back and said she was prepared to take it. It is possible he gave it to her at the first consultation so she could read the pros and cons in the packet but the time of 'dispensing' is not in the notes so we do not actually know."

2. *In response to the question of Aropax prescribing, you stated that the drug was started in a good, careful way in someone prone to anxiety. Please clarify the reason for your opinion that Miss A was prone to anxiety.*

"I said [Miss A] was 'prone to anxiety' because of the notes from the consultation on the 31 December 1999 – 'General nonspecific anxiety most days …. Chat re anxiety and managing it with simple cog-Behavioural techniques', and the fact that she presented with an anxiety attack that day. My comment was probably also influenced by subsequent events and comments I read about, which showed anxiety to be a huge problem over the next few months, but I believe there was evidence of anxiety preceding the Dec 31 consultation in the notes from that day."

3. *In your original advice, you have stated that Lorazepam, Clonazepam and Prozac were appropriate to treat anxiety effectively and quickly. Mrs A has questioned why Miss A remained in a state of extreme anxiety requiring the prescription of Clopixol. Please comment.*

"In my original advice you say I stated Lorazepam, Clonazepam and Prozac are appropriate ways to treat anxiety effectively and quickly – I apologise if I did not distinguish between these agents more, but I think I said that the lorazepam and clonazepam are quickly effective anti-anxiety agents. Prozac is a reasonably quickly (over days to weeks, not minutes like the benzodiazepines) acting **anti-depressant** with some anti-anxiety properties. Sometimes these medications do not control the symptoms enough and I think that is why she was referred to a specialist who started her on clopixol. As I said in my original opinion this is a drug I had never heard of before and can only be prescribed by a specialist psychiatrist. It is an anti-psychotic and probably used because [Miss A's] symptoms were not settling with the medication we GPs usually use for this sort of problem. This may have been for the reasons [Mrs A] suggests – that [Miss A] was developing dependence and withdrawal symptoms from the benzodiazepines, or because of reactions to the combinations of medications she was taking, or it may have been for reasons [Mrs A] does not go into – interactions with these pills and alcohol, or because of the nature of [Miss A's] underlying illness."

4. *Could you please clarify the dose of Lorazepam that was prescribed on 31.12.99? Dr B's records are for 20 Lorazepam, 500 mcg 2-4 prn tds. The pharmacy instructions stated "dissolve one to two tablets in the mouth when required". Are you able to clarify this discrepancy?*

   "[Dr B's] notes record he prescribed 20 Lorazepam 500mcg 2-4 prn but the chemist's instructions were one to two tablets in the mouth when required. As I said in my original letter – it used to be possible to prescribe 500mcg or 0.5mg tablets of lorazepam but they were taken off the market some time ago (I am not sure when) and now only the 1mg (1000mcg) or 2.5mg tablets are available. Some of these tablets dissolve in the mouth and some are to be swallowed. Hence the instructions on the pack not being the same as [Dr B] prescribed. Because the chemist was giving a stronger dose he should not have given so many tablets – there should have been ten in each prescription instead of 20. I hope this clarifies the discrepancy. Prn means as required."

Commissioner's Final Opinion

Mrs A's view is that Dr B made an inappropriate decision to commence Miss A on medication when he first saw her on 31 January 1999. She also expressed concerns about the combination of medications he prescribed, as well as the risks associated with the individual medications. Mrs A feels that these risks were not discussed with Miss A in sufficient detail, and that Dr B did not ensure Miss A was adequately monitored once on medication.

Inappropriate decision to commence medication

My advisor comments that Dr B took good notes the first time he saw Miss A on 31 December 1999. Dr B's notes record his view that Miss A may have a mild depressive illness as well as anxiety. Although he did not specifically state his opinion on how severe Miss A's anxiety was in his medical notes on 31 December 1999, he did note that Miss A suffered from carpopedal spasm (where the hand and foot muscles go into spasm from hyperventilation). In my advisor's view this is a reasonably severe manifestation of anxiety. Mrs A expresses a preference for non-medical treatments of symptoms like anxiety. My advisor acknowledges this, but notes that this is not what most general practitioners are trained to do. In any case Dr B's notes do show that he discussed simple cognitive behavioural techniques for treating anxiety as well as medication.

Similarly, Mrs A refers to a number of guidelines to support her view that initial medical treatment should have been delayed in order to further clarify Miss A's diagnosis. However, Dr Corkill points out that these documents are guidelines not protocols. In Dr Corkill's view it was not necessary for a diagnosis of generalised anxiety disorder (GAD) to be made before offering medication for Miss A's episodic anxiety. Dr Corkill informed me that pathological anxiety other than GAD can be treated with lorazepam. I am guided by Dr Corkill on these matters and accept that it was not necessary or appropriate for Dr B to delay Miss A's medical treatment in order to further clarify her diagnosis.

Overall, I agree with my advisor that it was reasonable for Dr B to commence medication on the basis of the information that was available to him on 31 December 1999. I also agree with Dr Corkill's view that there is no evidence to indicate that Miss A's only initial problem was migraine. I note that Mrs A was not present at this consultation and the notes taken at the time clearly indicate that anxiety was the main topic discussed at the consultation.

Appropriateness of the medication prescribed
Mrs A has expressed concerns about the adverse effects of various medications prescribed for Miss A. Dr Corkill acknowledges there are inherent dangers in all drugs. However, in Dr Corkill's view, in Miss A's case the potential benefits of the drugs outweighed the risks to Miss A. This was also Dr B's view on the basis of the information he had available to him at the time. Miss A agreed to take the medication she was prescribed and there is no evidence to support Mrs A's view that the risks of these medications were not discussed with Miss A in sufficient detail, or that Miss A expressed concerns to Dr B about taking them. Likewise, there is no evidence to support Mrs A's concern that the combinations of medications prescribed were inappropriate. In my view the evidence does not show that the medication that Dr B prescribed to Miss A was inappropriate, on the basis of the information available to him at the time.

Monitoring of medication
Dr Corkill is of the view that Dr B took sufficient steps to ensure Miss A was monitored once on medication. These steps include suggesting Miss A start a low dose of Aropax after her plane trip, asking her to find a new general practitioner once in the new town, and giving her some lorazepam to take as needed in the interim. As Miss A presented with symptoms of severe anxiety and was also preparing to move to another area, I agree that these were reasonable steps to take in the circumstances.

Summary
I have carefully considered all of the information Mrs A supplied as well as my advisor's additional comments. In my opinion, none of this information changes my view that Dr B provided services to Miss A with reasonable care and skill. Accordingly, it is my opinion that he did not breach Right 4(1) of the Code. In my view, there is no evidence that he provided insufficient information to Miss A and therefore I also find that he did not breach Right 6(1) of the Code.

Action

- A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

General Practitioner, Dr C
Final opinion – 01HDC14511

Complaint

On 10 December 2001, I received a complaint from Mrs A concerning services provided to her late daughter, Miss A, by various health providers. On 24 June 2002, I commenced an investigation into the particular services general practitioner Dr C provided to Miss A.

The complaint against Dr C was summarised as follows:

Dr C, a general practitioner in the new town, did not provide Miss A with services of an appropriate standard between January and May 2000. In particular:

- *Dr C inappropriately prescribed regular clonazepam for Miss A over a period of months, despite Miss A complaining of side effects.*
- *Dr C inappropriately prescribed Prozac (fluoxetine) for Miss A in combination with clonazepam, Sandomigran (pizotifen) and "over the counter" drugs including, Panadeine, Panadol and Mersyndol.*
- *Dr C did not adequately involve Miss A's family in discussions about Miss A's diagnosis and treatment.*

Dr C did not provide Miss A with sufficient information. In particular:

- *Dr C did not adequately explain the diagnoses of anxiety and depression to Miss A.*
- *Dr C did not adequately explain the options available for treatment of panic attacks and anxiety, including the option of behavioural therapy.*
- *Dr C prescribed regular clonazepam for Miss A without adequately explaining the risks of clonazepam, including tolerance and dependency.*
- *Dr C prescribed regular clonazepam for Miss A without explaining the importance of restricting alcohol intake while taking clonazepam.*
- *Dr C prescribed regular clonazepam for Miss A without explaining the potential side effects of clonazepam, including disinhibition, depression, headaches and drowsiness.*
- *Dr C prescribed Prozac (fluoxetine) for Miss A without adequately explaining the potential side effects of Prozac (fluoxetine), including nervousness, headache, and paranoid reactions.*

Information gathered

During my investigation I received information from Mrs A and Dr C. I also obtained independent advice from general practitioner Dr Caroline Corkill. A copy of Dr Corkill's advice is attached.

Dr C was Miss A's general practitioner from late January 2000, when she moved to the new town from her hometown to work as a tutor, until late May 2000 when she moved back to her hometown.

Dr C's first contact with Miss A was on 28 January 2000. He advised me he was called to her flat because she was having a debilitating hyperventilation attack. I note Mrs A's advice that she had never seen her in such an extreme state. When Miss A consulted Dr C at his rooms a few days later on 1 February 2000 she was hyperventilating again. Dr C advised me that he observed Miss A's debilitating anxiety symptoms on several occasions, her panic attacks involving hyperventilation, prostration, carpopedal spasm, tachycardia, pallor, weakness and tremor. Dr C advised me that because of the degree of debility Miss A was suffering, and because he wanted to be sure of his working diagnosis, he wanted to refer Miss A to a psychiatrist at an early stage. When Miss A refused, Dr C started treatment.

On 28 January 2000, Dr C commenced Miss A on clonazepam. He advised me that he explained to her that it was a benzodiazepine with anxiolytic effects, and could be used to control acute anxiety attacks. Dr C advised me that at various consultations he spent a lot of time discussing Miss A's condition with her, and various treatment modalities. Dr C suggested Miss A try using a paper bag to re-breathe when having an anxiety attack, but she insisted she should be able to settle it on her own. He suggested stress relaxation exercises, and encouraged her to do regular exercise in the form of walking or cycling. He discussed the importance of good nutrition with her, noting that she was underweight. At the consultation on 1 February 2000, Dr C gave Miss A the contact number for a counselling service, and he telephoned the local Presbyterian minister and arranged for Miss A to contact him.

Dr C gradually increased Miss A's clonazepam from 0.25mg to 0.5–1mg twice daily. He advised me:

> "[Miss A] derived benefit from this medication. It helped her assume a better level of functioning, but I did reinforce the point that it was a temporary measure and that ideally we would want to slowly withdraw it."

He advised me that he took care to explain to Miss A that clonazepam can cause drowsiness, disinhibition, and dependency with long-term use. He therefore recommended its cautious use, and prescribed the lowest dose that appeared to control most of her symptoms. He also annotated the prescription form so that she was dispensed only weekly amounts. At the consultation on 1 February 2000, Dr C recorded that Miss A told him that she had experienced her first hyperventilation/panic attack two years earlier at her grandmother's funeral, and that she found alcohol a great stress reliever. Dr C advised me that he warned Miss A about the importance of not combining alcohol with clonazepam.

Mrs A advised me that Miss A did not hyperventilate at the funeral, and Mrs A was not aware of this happening until she moved to the new town. Mrs A also felt it was incorrect to say that Miss A used alcohol as a stress reliever. She advised that if Miss A used alcohol inappropriately this only occurred on isolated occasions.

In relation to his prescribing of Prozac, Dr C advised me that anxiety disorders and depression often co-exist, and that anxiety symptoms often ease as the coexistent depression resolves with treatment. In February 2000, Dr C discussed with Miss A the possibility of

starting Prozac, explaining to her that it might also help control her anxiety and reduce her need for clonazepam. However, Miss A was initially reluctant as she understood that Prozac was related to Aropax. She had previously taken one Aropax tablet, and associated this with her first panic attack in the new town. She therefore preferred to continue on clonazepam on its own.

Dr C started Miss A on Prozac on 17 March 2000, when he was called to her home after her employer had taken her home when she experienced a bad anxiety attack at work. Dr C advised me that he made it clear to Miss A that in the starting phase, symptoms of anxiety could potentially worsen, then improve. Dr C advised me that Miss A remained under close follow-up, and that there was no evidence of paranoid reactions. Had there been such reactions, he advised me that he certainly would have acted.

Dr C was aware that Miss A was taking Sandomigran and Mersyndol for her migraines. He advised me that he was alert to the possibility of drug interactions, but on balance thought it reasonable to continue with Sandomigran rather than risk a situation where Miss A was suffering more migraines alongside her panic disorder. Dr C advised me that Miss A felt drowsy when using Mersyndol (which contains a sedating antihistamine) in conjunction with clonazepam. Miss A told Dr C that panadol on its own was insufficient to control her migraines. Dr C therefore prescribed Panadeine in preference to Mersyndol. Dr C recorded in Miss A's medical notes that he was attempting reduction of her clonazepam on 13 April 2000.

In relation to Dr C not involving the family in discussions about Miss A's diagnosis and treatment, Dr C advised me that at an early stage Miss A asked him not to discuss her medical details with members of the family. That advice is supported by entries in Dr C's clinical notes.

Independent advice to Commissioner

The following expert advice was obtained from Dr Caroline Corkill, a general practitioner:

> "I am a general practitioner in Invercargill. I have been asked for independent advice in this complaint against two general practitioners and their management of a young woman who subsequently committed suicide.
>
> I have been sent and have read the following:
> - A copy of the Commissioner's notification of investigation to [Dr C] dated 14 August 2002, marked 'C'.
> - A copy of [Dr C's] responses to the Commissioner's investigation dated 30 July 2002 and 27 August, and attachments, marked 'D'.
>
> These attachments included [Miss A's] medical notes from … where [Dr C] worked, a letter from [Dr C] to someone whose name is not stated dated 3 February 2000, a letter from [Miss A] to [Dr C] dated 18/4/00, a letter from [Dr C] to [Miss A] dated 27 April 2000 and a copy of an article from New Ethicals Journal July 2002 'The management of generalised anxiety disorder.'

There are also five pages of notes from [the first public hospital] regarding assessments on 24 May 2000 and 30 May 2000 in the group of documents marked 'B' which are relevant to this part of the complaint.

The particular questions asked of me about the complaint against [Dr C] are:

1. Please comment on the allegation that it was inappropriate for [Dr C] to prescribe regular clonazepam for [Miss A] over a period of months, despite [Miss A] complaining of side effects. What are the side effects of clonazepam? Do I consider this prescribing to be appropriate?
2. Please comment on the allegation that it was inappropriate for [Dr C] to prescribe Prozac in combination with clonazepam, Sandomigran (pizotifen) and 'over the counter drugs' including, panadeine, Panadol and Mersyndol. Do I consider this prescribing to be appropriate?
3. Please comment on the allegation that [Dr C] did not adequately involve [Miss A's] family in discussions about [Miss A's] diagnosis and treatment. In what circumstances is it appropriate to involve family?
4. What information should a reasonable general practitioner provide about the diagnoses of anxiety and depression?
5. What options should a reasonable general practitioner explain for treating panic attacks and anxiety?
6. What information should a reasonable general practitioner provide about the risks of clonazepam?
7. When a person is prescribed clonazepam, what information should a reasonable general practitioner provide about alcohol intake?
8. What information should a reasonable general practitioner provide about the potential side effects of clonazepam?
9. What information should a reasonable general practitioner provide about the potential side effects of Prozac?

Overall, do I consider that [Dr C] provided [Miss A] with an appropriate standard of care? Please comment on any other matter I consider relevant.

Answers:

1. Clonazepam is a long acting anti-anxiety medication and as such it is thought to be less likely to cause dependence than some other anti-anxiety drugs. I think it is quite reasonable to use this to treat chronic anxiety though many general practitioners would try and use an antidepressant which is even less likely to cause dependence. [Dr C] does try to do this and I will comment on that in a later question. The main side effects of clonazepam are sedation which is noticed as fatigue and in large doses respiratory depression. It is a benzodiazepine so there is a risk of tolerance or dependence but as I mentioned before it is less likely to occur with this medication than with the shorter acting benzodiazepines. It is hard to know whether [Miss A] did complain about adverse affects as when this drug was being used on its own she did not seem to have any problems with side effects. The main problem I can see is that she still had episodes of hyperventilation and anxiety which were a major

disruption to her life. When I read my own copy of New Ethicals to check the side effects of clonazepam I did note that under the word 'rarely' it says clonazepam can cause blood dyscrasias, urticaria, rash (any drug can cause the last two) and then mentions 'paradoxical effects eg aggressiveness, psychoses, new types of seizures …' I have come across this once and it was most peculiar, the patient reacted to any benzodiazepine like this and so did some other members of her family. There does not seem to be any suggestion this was happening in [Miss A], but I wonder if her family has worried about this if, since her demise, they have read information about possible but rare side effects of her drugs.

2. I think [Dr C's] decision to prescribe Prozac, even though he knew [Miss A] took clonazepam, Sandomigran and 'over the counter' drugs including panadeine, Panadol and mersyndol, was perfectly reasonable. As one of the SSRIs (Selective Serotonin Reuptake Inhibitors) it is a very useful antidepressant with some antianxiety properties. I think it is a reasonable drug to use on its own or in combination with these drugs for the sorts of symptoms [Miss A] was suffering.

3. [Dr C] did involve [Miss A's] mother, [Mrs A]. I see in his notes that three days after his first visit to [Miss A], the day after first seeing her in his surgery, 'D/W Mum …' This usually means 'discussed with Mum' so it appears to me she and [Dr C] were in contact right from the start. This might not have continued as it is recorded in the consultation of 21 March 2000 'She does not want her Mum to know about these details …' This is common with adult patients and a basic right of theirs when consulting with a doctor. In my opinion, a general practitioner is safer to enlist the help of others like counsellors, mental health teams and the local minister, when dealing with a woman like [Miss A]. The family may be helpful but may be part of the problem. They may wish to be included while the patient may not want their inclusion. I do not think you can say the family should have been more involved.

4. I think a reasonable general practitioner should try and pitch their explanation of anxiety and depression to what they know the particular patient is feeling and what they think that person will understand and remember, so it is hard to make rules for what should be said. The main point in this case would be to explain that anxiety and depression are often related even though the patient may not feel 'depressed' or have classic symptoms of depression like appetite change ([Miss A] strongly denies this though the physical evidence of a BMI of 15 makes it a possibility), sleep disturbance and loss of motivation etc. In his letter to the Commissioner, [Dr C] says he explained about the physical manifestations of anxiety, how they overlap with depression, how blood tests can be helpful to exclude possible organic causes and that a variety of techniques and treatments can be helpful. It appears from this letter and his notes that he and [Miss A] discussed breathing techniques, exercise, counselling (an option she took up) and the importance of good nutrition, as well as medication.

5. I think a reasonable general practitioner would explain that there are a variety of ways to treat anxiety and panic attacks. These include breathing techniques,

relaxation techniques, regular exercise, support from counsellors, friends or family and medication. Often patients have tried the non-medicinal options before consulting a doctor. I think the notes and [Dr C's] letter suggest some of these options were discussed. This means the doctor usually focuses on the medical treatments available. The commonest quick-acting anti-anxiety medication is probably lorazepam, with diazepam or clonazepam being used if the anxiety is more chronic or ongoing. Antidepressants are the other groups commonly used for their anti-anxiety effect and because anxiety is a part of depression for some people. The choice of which antidepressant then falls to the doctor and what he or she has good knowledge about, and what they think will best suit the symptoms the patient is having. SSRI's like paroxetine and fluoxetine are common first line treatments of depression in general practice currently. They have the advantage of working faster than old fashioned antidepressants like the tricyclic family and with less sedation. They have the disadvantage of aggravating symptoms of anxiety in some people. Despite that, paroxetine is specially recommended for the treatment of panic attacks. The aim is to try to prevent them, rather than to take something at the time of the attack the way is done with lorazepam.

As you can see there are lots of possibilities and you could spend all day talking about the options with a patient. This is not possible in general practice so you are always left hoping you have judged appropriately what to say and what to omit. I think the notes suggest a reasonable discussion about options took place as there are records of discussing previous medication, alcohol, counselling, exercise, breathing techniques and new options for medicinal treatment of anxiety and panic attacks.

6. The risks of clonazepam were discussed in the answer to 1. I think a reasonable general practitioner should have told a patient about the risk of sedation and tolerance but would have been unlikely to mention paradoxical effects like aggression and seizures as this would be so rare and tend to put anxious patients off trying this useful drug.

7. I think a reasonable general practitioner should have mentioned possible interactions between clonazepam and other mind-altering drugs including alcohol. I think it is sometimes forgotten by even responsible general practitioners so I am grateful that pharmacists reinforce this message orally and in print on the container of pills. [Dr C] says he discussed the interaction of alcohol and clonazepam and I think this is likely as he did display a reasonable knowledge of her use of alcohol.

8. I think I have answered this question in answers 1 and 6. Risks and side effects are covered when a doctor is giving information about a drug.

9. A reasonable general practitioner should advise patients about the balance between the desired good effects and the possible bad effects – for Prozac, one warning is that other people who hear about them taking this drug will often try and talk them out of it because of the mixed messages in the media about it. It is worth saying some people get tremor, headache, nausea or trouble sleeping when they first start it, so it is best taken in the morning with food. These symptoms are very like anxiety

attacks so can be quite frightening for the patient. [Dr C's] explanation of how he suggested Prozac as a way of helping both [Miss A's] mood effects and anxiety with the aim of trying to reduce the clonazepam makes sense. He explained it was like Aropax, which she had had before, but slightly different. I think it was a reasonable choice, given that [Miss A] did not want to try paroxetine (Aropax) again.

Overall, I consider that [Dr C] provided [Miss A] with an appropriate standard of care.

If you need any further questions answered please let me know."

The Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights apply to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Commissioner's Provisional Opinion

Inappropriate prescribing of clonazepam
Dr Corkill advised me that in her opinion it was quite reasonable to use clonazepam to treat chronic anxiety. She noted that as a long-acting anti-anxiety medication, clonazepam is thought to be less likely to cause dependence than some other anti-anxiety drugs. Dr Corkill commented that many general practitioners would try to use an anti-depressant, which is even less likely to cause dependence. For that reason Dr C did later commence Miss A on Prozac.

Dr Corkill observed that it was hard to know whether Miss A complained to Dr C about adverse effects from clonazepam. The main side effects were sedation and, in large doses, respiratory depression. Dr Corkill noted that when clonazepam was used on its own Miss A did not seem to experience side effects. Dr Corkill advised me that in her general practice she had once come across a patient who experienced a rare side effect of clonazepam, being paradoxical effects of aggression, psychosis, and seizures. She noted there was no suggestion Miss A had experienced such effects from clonazepam.

I am guided by Dr Corkill's advice that Dr C's prescribing of clonazepam was appropriate.

Inappropriate prescribing of Prozac in combination with other medications
Dr Corkill advised me Dr C's decision to prescribe Prozac was perfectly reasonable. She advised me that, as an SSRI (selective serotonin re-uptake inhibitor), Prozac is a very useful anti-depressant with some anti-anxiety properties. In Dr Corkill's opinion, it was a reasonable drug to prescribe for the sorts of symptoms Miss A was suffering, either on its own or in combination with the other medications she was taking.

I accept that advice, and I further note that when Miss A complained that Mersyndol made her feel drowsy in conjunction with clonazepam, Dr C prescribed Panadeine in preference. I consider that Dr C was alert to possible drug interactions and that he prescribed appropriately.

Inadequate family involvement
I note Dr C's advice that Miss A requested him not to discuss her medical details with her family, and that there are entries in the clinical notes to that effect. I also note that Miss A was living independently in the new town. Dr Corkill advised me that, in her experience, it is common for adult patients not to want their families involved. She also noted that it is the right of adult patients to have that wish respected. In her opinion, it is more appropriate for general practitioners to enlist the help of other professionals.

In my opinion, it would have been inappropriate for Dr C to have discussed Miss A's medical details with the family, especially given that she had specifically requested him not to. The relationship of trust and confidence between doctor and patient would have been jeopardised had Dr C ignored her request at this early stage of her treatment.

Insufficient information about diagnoses
I asked Dr Corkill to advise me what information a reasonable general practitioner should provide a patient about diagnoses of anxiety and depression. Dr Corkill advised me that it was difficult to make rules for exactly what should be said, as in her opinion general practitioners should try to pitch their explanation depending on what they know the particular patient is feeling and what they think that person will understand and remember. In Miss A's case, Dr Corkill considered the important thing was to explain that anxiety and depression are often related even though the patient may not feel "depressed" or have classic symptoms of depression like appetite change, sleep disturbance and loss of motivation. She noted that Dr C had discussed with Miss A the physical manifestations of anxiety and how this overlaps with depression. He had taken blood tests to exclude possible organic causes and discussed with her a variety of techniques and treatments that could be helpful.

I accept that Dr C spent time discussing Miss A's condition with her and that he gave her adequate information about his diagnoses.

Insufficient explanation of treatment options
Dr Corkill advised me that a reasonable general practitioner would explain that there were a variety of ways to treat anxiety and panic attacks, including breathing techniques, relaxation exercises, regular exercise, support from counsellors, friends or family, and medications. Dr Corkill noted that often patients have tried the non-medication options before they consult a doctor. For that reason, doctors would usually focus on the medical treatment options available.

Dr Corkill considered that the clinical notes suggested Dr C had reasonable discussions with Miss A about treatment options. I agree, and in my opinion Dr C provided Miss A with sufficient information about the options available to treat panic attacks and anxiety. As well as stressing the importance of good nutrition, and encouraging Miss A to do regular exercise, Dr C suggested options such as re-breathing to control anxiety. He also provided Miss A with contact details for support from a counselling service and the local Presbyterian minister. In my opinion, he provided Miss A with adequate information about a variety of treatment options.

Insufficient information about clonazepam – risks, side effects, importance of restricting alcohol intake
Dr Corkill advised me that the main side effects of clonazepam are sedation and, in large doses, respiratory depression. As a benzodiazepine, there is a risk of tolerance and dependence, but because clonazepam is a long-acting anxiolytic it is thought less likely to cause dependence than some other anti-anxiety medications.

Dr Corkill advised me that a reasonable general practitioner would have told a patient about the risk of sedation and tolerance. I note that Dr C did advise Miss A of these risks, and that he therefore recommended the cautious use of clonazepam and prescribed the lowest dose that appeared to control most of Miss A's symptoms. I note that Dr C also annotated Miss A's prescriptions so that she was only dispensed weekly amounts.

Dr Corkill advised me that it would be unlikely for a reasonable general practitioner to mention the paradoxical effects such as aggression and seizures. Dr Corkill advised me that paradoxical effects are rare, and telling an anxious patient about them might put the patient off taking the medication.

Dr C was aware of Miss A's alcohol use, and he discussed with Miss A the interaction of alcohol with clonazepam. Dr Corkill advised me that even responsible general practitioners sometimes forget to provide this information, and she noted her gratitude that pharmacists reinforce the message about restricting alcohol intake.

In my opinion, Dr C provided Miss A with adequate information about clonazepam.

Insufficient information about Prozac
Dr Corkill advised me that before prescribing medications a reasonable general practitioner should inform the patient about the balance to be achieved between the desired good effects and the possible bad effects. With Prozac, Dr Corkill considered a reasonable general practitioner might warn the patient that other people might try to talk them out of taking the medication, because of the mixed messages in the media about it. When first starting Prozac, some people experienced tremor, headache, nausea or trouble sleeping. A general practitioner might therefore recommend it be taken in the morning with food.

Dr C suggested Prozac for Miss A as a way of helping her with both mood effects and anxiety. Dr Corkill considered Dr C had provided Miss A with an explanation about Prozac that made sense. He also told her that Prozac was similar to Aropax, but slightly different. Given that Miss A had previously tried Aropax and did not want to take it again, Dr Corkill considered Dr C's choice of Prozac was reasonable.

Summary
Dr Corkill advised me that in her opinion Dr C provided Miss A with an appropriate standard of care. She considered that his prescribing of clonazepam, and of Prozac in combination with the other medications she was on, was appropriate.

Dr Corkill advised me of the information a reasonable general practitioner should give a patient about the risks and side effects of clonazepam, and the importance of restricting alcohol intake when taking clonazepam. I have no reason to doubt that Dr C discussed this information with Miss A and that he gave her adequate information about the medications he prescribed. I also have no reason to doubt that Dr C gave Miss A adequate information about various treatment options and his diagnoses.

In my opinion, therefore, Dr C provided Miss A with services of an appropriate standard, and did not breach Right 4(1) of the Code. Dr C also provided Miss A with adequate information and did not breach Right 6(1) of the Code.

Response to Provisional Opinion
Mrs A supplied extensive information responding to my provisional opinion that Dr C did not breach the Code. I forwarded the information to Dr Caroline Corkill for further comment and also to ascertain whether any of the material supplied changed her view.

Further advice to Commissioner
My advisor's further comments, made in response to questions put to her, are outlined below.

1. *Is clonazepam indicated for the treatment of anxiety, as well as epilepsy?*

   "No, clonazepam is not formally indicated for the treatment of anxiety, just for epilepsy. I have followed up [Mrs A's] comments to this effect and found she is quite correct in this comment. However, I do know that it is widely used by some doctors for the treatment of anxiety, and that is why I had not realised it was not indicated for this purpose."

2. *Does any of the information supplied cause you to change your opinion that Miss A was allowed to remain on clonazepam for too long?*

   "I think [Miss A] first was given clonazepam on the 28.1.00 when [Dr C] did a home visit for an acute anxiety attack. I make this assumption on the basis of his letter to you in which he says he did a home visit then, the notes from 1.02.00, and corroborated by [Mrs A's] comments. There are no computer notes for this first visit at home, I do not know if there were any handwritten ones. He says he started her on 0.25mg daily, then increased it to 0.5mg daily. On 9 February 2000 he gave her a prescription for 0.5mg (500mcg was how he wrote it) daily for one month – 30 tablets. The next computer record is for the 21 March where he says she is taking 0.5mg twice a day, but he notes there have been two home visits in the interim and I do not know if he prescribed more clonazepam for her at those times because there is no computerised record of these visits or prescriptions that I have seen. I did see the list of pharmacy records assembled by [Mrs A] on pages 3-8 and 3-9 in her document 'Finding answers and reaching understanding of the anxiety state, medication and suicide', but this does not easily link with when [Dr C] wrote the prescriptions he records in the notes. This suggests to me that he either gave her some medication at the time of the home visits or she used another chemist to fill the prescriptions in February in particular. [Dr C] continued to prescribe clonazepam for her for about ten weeks (all of February, March and two weeks of April) before he records that he is asking [Miss A] to reduce the amount of clonazepam she is taking. When I compare his notes with the pharmacy records in [Mrs A's] original document it seems that the clonazepam prescribing became particularly frequent at the end of March when the 30 tablets in each prescription were only lasting a week despite [Dr C] thinking she was taking one tablet twice a day. To go through 30 a week is slightly more than 4 a day. It is at this point I think it would have been helpful to notice the growing tolerance of clonazepam that [Miss A] would seem to have been developing. In summary, my answer to this question would be that I do not think [Dr C] allowed [Miss A] to stay on clonazepam for too long but he probably should have

been worried about her increased use of the drug. I can see how it might have happened if he felt she was making progress with her management of the anxiety attacks. It is very difficult to stop a patient using more of a drug like clonazepam if they find it helps them feel better, especially when she was still using the lower daily dose recommended in New Ethicals. This book recommends 2-4 mg daily and even if she were taking 4 x 0.5mg tabs that would have been 2mg daily. In summary [Miss A] was using clonazepam long enough for me to have some concerns about its continued use but not 'too long'."

3. *Was Miss A demonstrating sensitivity to benzodiazepines? What are the usual signs of sensitivity?*

"I am not sure what you or [Mrs A] mean by the use of 'sensitivity' to benzodiazepines. I think it usually means a low dose of the drug is effective in a person. The trouble with using benzodiazepines for a while is it makes you less sensitive, ie you need more drug to have the same effect. I think (I may be wrong) that [Mrs A] may mean 'susceptible to the adverse effects' when she uses the word 'sensitive'. She may well be right, that [Miss A] was sensitive/susceptible to benzodiazepines, but I do not think this would necessarily have been evident to [Dr C] at the start."

4. *In view of the first public hospital's differential diagnosis "? element of benzodiazepine withdrawal" on 27/1/00, was it inappropriate for Dr C to prescribe clonazepam on 28/1/00?*

"[Mrs A] refers to '?element of benzodiazepine withdrawal' from a [the first public hospital] A & E visit on the 27/1/00, but I have not seen evidence of this visit anywhere else. This quote is not referred to by [Dr C]. Even if he was shown a document saying this, I don't think that would have been reason to stop him using a cautious dose of benzodiazepine – it might mean that was the most likely way to help, at least in the short-term."

5. *Please comment on the claim that Miss A was showing signs of dependency on, or tolerance to, lorazepam and clonazepam.*

"I think the first obvious sign that [Miss A] was showing signs of dependency on benzodiazepines was when she started getting through her 30 clonazepam tablets in shorter and shorter time. Her symptoms and signs of anxiety would have been hard to differentiate from withdrawal signs from benzodiazepines, or alcohol. I agree with [Mrs A's] comments in paragraphs 3, 11, 35-37 and 62 because the symptoms and signs [Miss A] was showing could well have been due to benzodiazepine withdrawal, but I maintain it could be very hard to distinguish this from her anxiety which came on before she took benzodiazepines. When you haven't known a patient for long, in particular before the illness or condition you are seeing them for, it can be very hard to recognise when you are making things worse. I accept, with the advantage of all the notes and letters and comments provided to me, that [Dr C's] prescription of clonazepam could have been making things worse."

6. *Was clonazepam contraindicated due to Miss A's hyperventilation? In the context of clonazepam prescribing, what does "severe respiratory insufficiency" mean, and is there any evidence Miss A suffered from this?*

"[Miss A's] hyperventilation was not a contraindication to clonazepam in my opinion. 'Severe respiratory insufficiency' to me means a serious reduction in a person's capacity to breathe in enough oxygen and transfer it into the blood stream. Diseases which reduce the amount of functioning lung include things like asthma, chronic obstructive pulmonary disease, tumours and many other physical problems, but I have never come across respiratory insufficiency referring to anxiety related hyperventilation. Hyperventilation like [Miss A's] is certainly a respiratory symptom/sign, but in my view, does not reflect any insufficiency of her respiratory system. [Mrs A] talks about benzodiazepines causing 'increased arterial carbon dioxide tension and decreased arterial oxygen tension'. I find this confusing and prefer to look at what is happening with hyperventilation and with benzodiazepine effects. Hyperventilation causes decreased amounts of carbon dioxide in arterial blood (hypocapnia) – the fast breathing blows off more CO_2 than usual, which increases the alkalinity of blood, and this is associated with tingling and spasms of hand and foot muscles. Respiratory depression, as can be caused by benzodiazepines, causes the opposite – slower breathing and hence less CO_2 being blown out. In short, benzodiazepines have the opposite effect on respiration from anxiety so are not contraindicated for this reason."

7. *Please provide general comments on Mrs A's claims about the inherent dangers of benzodiazepines, particularly clonazepam. Please include comment on Mrs A's opinion that clonazepam's risks outweigh its usefulness.*

"There are several dangers inherent in the use of benzodiazepines, the main ones being the risk of tolerance and dependence, with unpleasant symptoms like those of anxiety, when they are withdrawn. There are other possible side effects including drowsiness, respiratory depression, muscle weakness, coordination disturbances and the rest of the list in the New Ethicals Catalogue which [Mrs A] quotes. Rarely (as I said in my first letter) it is possible to get paradoxical effects of aggressiveness or psychosis. The effects of benzodiazepines can be exaggerated when used with other medications or alcohol, so there are more dangers if they are used in combination. I agree with [Mrs A's] highlighted quote in paragraph 77, 'Serious sequelae are rare unless other medicines, drugs or alcohol have been taken concomitantly.' This does raise the other issue which is only mentioned in passing in the notes and records I have been sent –that [Miss A] was using alcohol as a stress reliever ([Dr C's] notes), and the implication is that she might have been drinking enough to interact with her medication ([Mrs A's] highlighting of the interaction between alcohol and her prescribed drugs and the medical people's failure to tell her not to drink at all when taking her medications) and possibly to aggravate her problems.

It is [Mrs A's] opinion that clonazepam's risks outweigh its usefulness; and from [Mrs A's] point of view I can accept that. However as a GP who has seen it used successfully to manage anxiety in some patients without the problems [Miss A] had, I can assure you in some cases its usefulness outweighs the risks."

8. *Is clonazepam a long acting anti-anxiety medication, such that dependence is less likely?*

"I sought information from a colleague who runs the local drug and alcohol unit about the length of action of clonazepam and he gave me a chart from a reputable pharmacology text-book by Goodman and Gilman showing clonazepam as being long-acting with an elimination rate of 20-50 hours (compared with lorazepam, medium 10-20 hours, and diazepam, long 30-60 hours). He did say there are various charts around and they do not all have exactly the same values on them but they are pretty close, and [Mrs A] quotes 18-60 hours as its elimination time. She says this is medium to short-acting but in my opinion this is a long acting benzodiazepine. Benzodiazepines which are classified as long-acting are considered less likely to cause problems with dependence, but they all can."

9. *Does any of the evidence supplied change your opinion that "paradoxical effects are rare"?*

"The evidence provided by [Mrs A] does not change my opinion that paradoxical effects are rare. The quotes she gives to describe these effects use words like 'can be seen', 'while not common', and 'occasionally'. New Ethicals says they are rare, and my experience fits with that."

10. *Was Miss A showing signs of paradoxical effects of clonazepam?*

"I am not sure whether [Miss A] had paradoxical effects of the clonazepam – I think probably not. I accept her suicide attempts and success could be consistent with the aggressive and violent behaviour considered paradoxical with benzodiazepines, but they are also part of depressive illness behaviours. I think if [Miss A] had paradoxical effects from the clonazepam she would not have continued to take it for as long as she did."

11. *Please comment on Mrs A's claims that clonazepam was not effective in relieving Miss A's anxiety.*

"[Mrs A's] comments in paragraph 18 defend her opinion that clonazepam was not effective in relieving [Miss A's] anxiety. I think they are reasonable comments from her point of view, but I defend what I said about [Dr C's] use of the drug. From his notes it appears [Miss A] was reporting that the clonazepam was helping. 1.2.00 'has not had any more hyperventilation episodes until coming here today. legs went wonky.' 9.2.00 'She has had a better week … needs more clonazepam.' Why he needed to add Prozac was because she also had depression in his opinion, which the clonazepam would not have helped. [Dr C] raised the possibility of this early on, but accepted [Miss A's] hesitation about using an SSRI like Aropax or Prozac because she said she had associated a previous anxiety attack with Aropax."

12. Was Dr C over-prescribing clonazepam?

"I think I have answered this question in my answer to question 2. The short answer would be, 'Yes, but.' By April I think he was prescribing too much clonazepam, but in my opinion it was probably acceptable because (a) he was using less than the maximum recommended dose, (b) he was trying to reduce it, (c) he was trying to change her onto less addictive medication (Prozac) and (d) he was getting help from other health professionals ([a counsellor]). With hindsight it becomes easier to see how the number of prescriptions was building up whereas this can be very difficult to monitor at the time – especially if there is a mixture of computer notes and visits with handwritten or no records. [Mrs A] refers to twice weekly dispensing, which she says did not happen – I do not think the dispensing was ever written or suggested to be more frequent than once weekly."

13. Is there any evidence to change your opinion that the combination of drugs prescribed to Miss A was appropriate?

"Using combinations of drugs is always more risky than using individual ones and it is something doctors are taught to try to minimise – the reality is, it is often necessary and useful. In my opinion the combination being prescribed for [Miss A] was justifiable."

14. In relation to your advice that Prozac is a very useful anti-depressant, do the excerpts from "Talking Back to Prozac" (copy attached), alter your advice? Please comment.

"The excerpts from 'Talking Back to Prozac' are typical of the widely held view that Prozac should not be used at all because it causes people to be aggressive and commit suicide, and that it is a bad thing to use pills to improve mood. A Prescriber Update from the Ministry of Health (NZ) in September 2002 has an article by Professor Pete Ellis discussing the 'reports of fluoxetine and, more recently, paroxetine and sertraline being associated with aggressive or suicidal thoughts and behaviour. … It is possible that these adverse events can be attributed to akathisia (involuntary severe motor restlessness). However, the most common reason for self-harm behaviour during treatment with any antidepressant is worsening depression. The development of severe agitation or self-harm behaviour is an indication that the patient and their antidepressant therapy require prompt review.' I agree with this view. This is what started to happen when [Miss A] was admitted to [the first public hospital] twice after slashing her wrists – but the information given to the mental health unit was not the whole story. She was discharged both times at her request and declined any follow up with the mental health unit in [either of the towns]."

15. Does any of the information Mrs A has supplied about the benefits of involving family in mental health patient's treatment change your opinion about the appropriateness of Dr C's actions at the time?

"I stand by my comments about involving family in the care of a young adult patient – it can be extremely difficult to know who should be told what and how each person can help the patient the best. I think [Dr C], [Miss A] and [Mrs A] all struggled with this,

legal requirements for patient's privacy aside. Some things were obviously talked about with them all present and some things [Miss A] requested [Dr C] did not mention to her mother. [Mrs A] is selective in what she highlights in paragraph 56 from the Medical Council suggestions, not highlighting 'having first obtained the patient's consent.' There are benefits in involving family in the treatment of people with mental health issues but the reality of how to organise that is very difficult – especially for general practitioners who work around an average of 15 minute appointments and who are asked not to share some information. It sounds as though one of the reasons they chose [Dr C] was because he was prepared to make home visits and this obviously suited them. I think he discussed a reasonable amount with [Mrs A] as well as the patient. It is impossible to know exactly what was said at these consultations because they were never recorded verbatim and we do not have the benefit of [Miss A's] recollections, but I do not think there is enough evidence to say [Dr C] should have involved the family in any way other than he did."

16. *Are there any additional treatments that Dr C (or a reasonable general practitioner) should have discussed with Miss A in more detail?*

"I stand by the comments in my first letter of 11.03.03 in answer to question 5, that a reasonable general practitioner would explain there are a variety of ways to treat anxiety and panic attacks. I think the notes provide evidence that a reasonable range of these options were discussed. I disagree with [Mrs A] that you have to be drug free to practise these – that is just one view."

17. *Please review the information that Mrs A supplied about Prozac and SSRIs. Is there anything included that would cause you to change your advice about what Miss A should have been told about Prozac?*

"The additional information about Prozac supplied by [Mrs A] does not change my view about what [Miss A] should have been told about Prozac. As you will now have seen in the huge amount of information provided by [Mrs A] and the smaller amount by me there are many possible side effects from Prozac. Some of these are paradoxical, for example, Prozac may cause anorexia (loss of appetite) but is one of the most useful drugs for treating Anorexia Nervosa, it is a highly useful drug for the treatment of depression but it comes with a warning for caution in patients with 'agitation, suicidal tendency, major affective disorder' which are all part of depression for some people. The doctor's job when suggesting suitable medication is to tell the patient enough about the treatment for the patient to be 'fully informed' and able to give 'informed consent' without confusing them totally or putting them off taking something which could be life-saving."

18. *Is there any evidence that Miss A suffered an adverse reaction to Prozac?*

"I do not think [Mrs A's] comments in paragraphs 124-129 provide evidence that [Miss A] suffered adverse reactions to Prozac. When she came out of her room to ask what [Dr C] and her mother were talking about [Mrs A] says she found that a subtle form of paranoia. I think it was a reasonable question as it was to do with her health and only

three days earlier she had asked [Dr C] not to pass on certain pieces of information to her mother. What [Mrs A] … refer[s] to as 'toxic' effects are what I regard as reasonably common side effects which improve with taking the drug for a bit longer rather than getting worse as I would expect toxic effects to do. Saying that [Miss A] harmed herself on July 3 2000 because a man was watching her was after she had been treated at [the first public hospital's] Mental Health Unit and returned to [her hometown], so can hardly be attributed to any failure on [Dr C's] part in my opinion.

I do not accept the suggestion from [Mrs A] that Prozac was responsible for [Miss A's] suicidal behaviour for the reasons I gave in 14, but there are a number of people who would accept that suggestion. Most New Zealand doctors accept the view of the PreMeC Medicines Information bulletins of November 2002 that 'SSRIs are now the first line pharmacological treatment for depression in primary care, and SSRIs are generally well tolerated and safe medications for the treatment of depression.' However safe Prozac is, it does not suit everyone who needs treatment with an anti-depressant or anxiolytic. The psychiatrists who saw her did not seem to think the Prozac was causing an adverse reaction in her or they would have stopped it when they reviewed her."

19. *Does any of the supporting documentation that Mrs A supplied with her letter dated 12 June 2003 alter your opinion that Dr C provided Miss A with a reasonable standard of care?*

"The supporting documentation supplied by [Mrs A] in her letter dated 12 June 2003 does not alter my opinion that [Dr C] provided [Miss A] with a reasonable standard of care. My two reservations to that opinion are covered in my answers to questions 1 and 2, they are that [Mrs A] is right that clonazepam is not formally indicated for treatment of anxiety and the apparent lack of records about the home visits."

I sought further advice from Dr Corkill about her outstanding concerns as follows:

1. *In order to investigate the uses of Clonazepam we have contacted the manufacturer of this drug. We have been advised that although this drug is only indicated for epilepsy, doctors may use it for other reasons. The drug is only registered with Medsafe for control of epilepsy, and a copy of the product Datasheet from Medsafe is enclosed for your reference. In light of this information, are you able to make further comments about whether Clonazepam can be used for the treatment of anxiety?*

"Clonazepam can be used to treat anxiety. My assertion of this is based on experience as a general practitioner. Three of my patients have been referred back to me by psychiatrists (different in each case), who have started them on clonazepam for treatment of their anxiety. The Medsafe Datasheet you provided is full of interesting information I have not previously read but is consistent with other information about benzodiazepines I have read and heard about and seen in practice as a General Practitioner over the past 20 years. At the top of page 2 of the datasheet it states clearly, 'Clonazepam exhibits pharmacological properties which are common to benzodiazepines and include anticonvulsant, sedative, muscle relaxing and anxiolytic effects.' Anxiolytic means it reduces or stops anxiety. I spoke with Dr James Rankin,

Consultant Psychiatrist at Kew Hospital to ask him about the use of clonazepam as an anxiolytic. He said it is frequently used as an anxiolytic and is especially useful for night-time use because of its longer action than some of the other benzodiazepines used for treating anxiety like lorazepam."

2. *Please find enclosed the note of a telephone conversation that Dr C had with a staff member from this office in February 2003. Dr C advised that he was no longer able to locate copies of his handwritten notes of home visits. Does this alter your advice with regard to Dr C's record keeping?'*

"The note of a telephone conversation that [Dr C] had with a staff member of your office in February 2003 is helpful in explaining the unaddressed letter dated 3.2.00 and 24.5.00 which confused me when I first read the notes. It is a useful additional record of [Dr C's] impressions at the time of seeing [Miss A].

I think it is unfortunate there are no records, handwritten or computerised, for some of those home visits. I think it shows poor record keeping, but know that sometimes this happens, especially with combined computer-paper records. I am not sure whether it reflects poorly on [Dr C] or on the system used by … at the time."

Commissioner's Final Opinion

Mrs A expressed concern about the appropriateness of Dr C's decision to use clonazepam in the treatment of Miss A's anxiety. She was also concerned that clonazepam was contraindicated because of Miss A's episodes of hyperventilation. Mrs A is also of the view that Miss A was exhibiting signs of dependence on benzodiazepines that were not recognised by Dr C.

Inappropriate prescribing of clonazepam

I have taken careful note of Dr Corkill's comments on the appropriateness of the clonazepam that Dr C prescribed for Miss A. In response to my provisional opinion, Mrs A supplied information that indicated that clonazepam is not formally indicated for the treatment of anxiety, only for epilepsy. Dr Corkill initially confirmed that this is correct. However, the manufacturer of this drug advised my Office that although clonazepam is only formally indicated for epilepsy, it can be used for other purposes. In particular, Medsafe's product data sheet for this drug states:

> "Clonazepam exhibits pharmacological properties which are common to benzodiazepines and include anticonvulsant, sedative, muscle relaxing and anxiolytic effects."

Dr Corkill cited a number of cases where her patients had been started on this drug by psychiatrists. She further cited the advice of a consultant psychiatrist that clonazepam is frequently used as an anxiolytic (anxiety reducing drug), and that it is especially useful for night-time use because of its longer action than some of the other benzodiazepines. On the basis of this information, I am satisfied that clonazepam is an appropriate drug to use for the treatment of anxiety generally.

With regard to Dr C's use of this drug in Miss A's case, Dr C advised me he introduced it at a low dose, gradually increasing the dosage from 0.25 to 0.5-1 mg daily. He prescribed it at the lowest dose that appeared to control her symptoms. Furthermore, he advised that Miss A derived benefit from this medication.

In my view, Dr C was following a widely accepted practice prescribing clonazepam for Miss A's anxiety. I am satisfied that he exercised reasonable care in the use of this drug in the circumstances he faced. Accordingly, in my opinion he did not breach Right 4(1) of the Code in this respect.

Whether Miss A was prescribed too much clonazepam is a separate issue. I have noted that Dr Corkill had some difficulty ascertaining how much clonazepam Dr C prescribed to Miss A owing to absence of notes for home visits made by Dr C. However, Dr Corkill commented that there is evidence to indicate that Miss A's dependence on clonazepam could have been increasing over the period 28 January 2000 to 13 April when Dr C recorded that he was attempting a reduction of Miss A's clonazepam. Dr Corkill noted that by the end of March Miss A was taking a prescription of 30 tablets in approximately a week. Dr Corkill commented: "It is at this point I think it would have been helpful to notice the growing tolerance of clonazepam that Miss A would seem to be developing." However, although there is no record of an attempt to reduce Miss A's clonazepam until 13 April 2000, Dr Corkill also advised me that in her opinion his use of it "was probably acceptable because (a) he was using less than the maximum recommended dose, (b) he was trying to reduce it, (c) he was trying to change her onto a less addictive medication (Prozac) and (d) he was getting help from other health professionals (counsellor …)". In these circumstances, I agree that Dr C's prescription of clonazepam was appropriate and he did not breach Right 4(1) of the Code.

Was clonazepam contraindicated?

Mrs A expressed concern that clonazepam was contraindicated for Miss A because of her hyperventilation attacks. However, Dr Corkill disagrees. I note that there are precautions for use of this drug for people with respiratory impairment. Dr Corkill informed me that she could see no evidence that Miss A suffered from respiratory impairment. Dr Corkill informed me: "Hyperventilation like [Miss A's] is certainly a respiratory symptom/sign, but in my view, does not reflect any insufficiency of her respiratory system." Dr Corkill explained how benzodiazepines have the opposite effect on anxiety, and so are not contraindicated for this reason.

Signs of dependency

Mrs A has raised concerns that Miss A was showing signs of dependency on benzodiazepines. I accept that it is possible that Miss A may have been becoming dependent; in Dr Corkill's view, the first sign of this was when Miss A started getting through her 30 clonazepam tablets in shorter and shorter time.

I also acknowledge that the first public hospital did record a differential diagnosis of "? element of benzodiazepine withdrawal" on 27 January 2000. This was not a definitive diagnosis but raised a question for consideration. This document was sent to Dr C, but Dr

Corkill stated that she does not think this would have been reason to stop him using a cautious dose of benzodiazepine. She advised: "It might mean that was the most likely way to help, at least in the short-term."

I agree with Dr Corkill that it is possible that Dr C's prescription of clonazepam may have been making things worse. I acknowledge that Miss A's anxiety did get worse despite the medication regime that she was on. Dr Corkill also acknowledges that Miss A may have been susceptible to the adverse effects of benzodiazepines. However, I do not believe there is any evidence to indicate that these possibilities would have been evident to Dr C at the time. Dr Corkill highlights the difficulty of differentiating any possible signs of withdrawal from benzodiazepines from symptoms and signs of Miss A's pre-existing anxiety. Any signs and symptoms Miss A was experiencing could also have been attributed to her anxiety.

Summary

I have carefully reviewed the information supplied by Mrs A as well as Dr Corkill's additional comments. I accept that there are aspects of Miss A's treatment that could have been handled differently. However, in considering whether a provider has breached the Code, I need to be wary of hindsight bias and to form an opinion based on the information that was available to the provider at the time. Miss A presented to Dr C with a difficult problem of anxiety, which may or may not have been complicated by symptoms of benzodiazepine withdrawal. He prescribed clonazepam, in a cautious dose, to help control her anxiety. To the best of his knowledge this was an effective drug for the treatment of anxiety. He advised me that he told Miss A that this was a temporary measure and ideally it would need to be reduced. He continued to prescribe clonazepam to Miss A for about ten weeks before recording that he was attempting to reduce her dose. I am satisfied that Dr C provided care to Miss A with reasonable care and skill and on the basis of the information that was available to him at the time. In my opinion Dr C did not breach Right 4(1) of the Code. Furthermore, none of the information presented to me changes my view that Dr C supplied adequate information to Miss A while treating her. Accordingly, he did not breach Right 6(1) of the Code.

Additional comments

I have noted Dr Corkill's comments that it was difficult to determine the exact amount of clonazepam prescribed to Miss A because of the absence of some clinical notes, particularly related to Dr C's consultations with Miss A at her home. Dr C advised me that he was unable to locate copies of the handwritten notes taken at the time. He stated that these notes are normally kept on the patient's file and are sometimes later transcribed on to the computer. However, in Miss A's case the notes can no longer be located. I agree with Dr Corkill that this is poor record-keeping practice on the part of Dr C or his employer at the time. I have recommended that Dr C review his record keeping practice in this regard.

Recommendation
I recommend that Dr C review his record-keeping in relation to home visits.

Action
- A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.